OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.

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Adapalene, Differin[®], Epiduo[®] (adapalene-benzoyl peroxide) & Epiduo[®] Forte Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY HAVE BARCODES.

This form may be faxed to 844-403-1029.

	Member Informa	ation (required)	Р	rovider Info	rmation (red	quired)	
Member Name:			Provider Name:				
Insurance ID#:			NPI#:	NPI#: Specialty:			
Date of Bir	rth:		Office Phone:	Office Phone:			
Street Add	dress:		Office Fax:				
City:	State:	ZIP:	Office Street	Office Street Address:			
Phone:		City:	State:	State: ZIP			
		Medicatio	n Information	(required)			
Medication Name:			Strength:	(roquirou)	Dosage Form:		
			Directions for Use:				
			Information (re	quired)		☐ Yes ☐ No	
	he patient have a diagnos						
	e patient tried and failed E	BOTH of the followin	g products?	oducts?		☐ Yes ☐ No	
	Generic topical tretinoin Generic topical adapalene						
	· · · · · · · · · · · · · · · · · · ·	trial of generic topica	al tretinoin and gener	retinoin and generic topical adapalene products			
	be inappropriate for the p				' 		
Information	n on this form is accurate	as of this date.					
	er's Signature:	<u> </u>		Da	Date:		
Ara thara an	y other comments, diagnoses	s symptoms modication	ns tried or failed and/or	any other information	n tha nhysician fo	ools is important to	
this review?		s, symptoms, medication	iis tried of failed, and/or	any other information	ii tile pilysiciali le	seis is important to	
Please note:	This request may be denie			N OFF 044 0040			
	For more information about Monday – Friday: 8 a.m. to						

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